

# Healthcare Transformation Collaboratives Cover Sheet



**1. Collaboration Name:** Safety Net Electronic Medical Record Partnership

**2. Name of Lead Entity:** The Loretto Hospital

**3. List All Collaboration Members:**

The Loretto Hospital  
Roseland Community Hospital  
Saint Anthony Hospital  
South Shore Hospital  
St. Bernard Hospital  
Thorek Memorial Hospital  
Thorek Andersonville (Methodist) Hospital

**4. Proposed Coverage Area:**

Chicago (West Side)  
Chicago (South Side)  
South Cook County  
West Cook County

**5. Area of Focus:** Modernizing EMR infrastructure for seven safety net hospitals and outpatient settings

**6. Total Budget Requested:** \$36,413,865



Safety-Net Hospital Electronic Medical Record Partnership

Prepared by Loretto Hospital

for Department of Healthcare and Family Services Healthcare Transformation Collaboratives

**Primary Contact: George Miller**

## Application for Transformation

### Funding Cover Sheet

**Primary Contact for Collaboration**Entity Name The Loretto HospitalPrimary contact George MillerPosition President and Chief Executive OfficerEmail RedactedOffice Phone 773-854-5000Mobile Phone RedactedAddress 8012 S Crandon Ave, Chicago, IL 60617

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**List of entities participating in the collaboration:**Entity Name The Loretto HospitalPrimary contact George MillerPosition President and Chief Executive OfficerEmail RedactedOffice Phone 773-854-5000Mobile Phone RedactedAddress 645 South Central Avenue, Chicago IL 60644

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**List of entities participating in the collaboration:**Entity Name Roseland Community HospitalPrimary contact Robert VaisPosition Chief Financial OfficerEmail RedactedOffice Phone 773-995-3044Mobile Phone RedactedAddress 45 W 111th St, Chicago, IL 60628

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**List of entities participating in the collaboration:**

Entity Name Saint Anthony Hospital

Primary contact Randy Stein

Position Executive Director Revenue Cycle

Email Redacted

Office Phone 773-484-4807

Mobile Phone Redacted

Address 2875 West 19th Street, Chicago, IL 60623

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**List of entities participating in the collaboration:**

Entity Name South Shore Hospital

Primary contact Timothy Caveney

Position President and Chief Executive Officer

Email Redacted

Office Phone 773-356-5200

Mobile Phone Redacted

Address 8012 S Crandon Ave, Chicago, IL 60617

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**List of entities participating in the collaboration:**

Entity Name St. Bernard Hospital

Primary contact Robert Springer

Position Chief Financial Officer

Email Redacted

Office Phone 773-962-4210

Mobile Phone Redacted

Address 326 W 64th St, Chicago, IL 60621

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**List of entities participating in the collaboration:**

Entity Name Thorek Memorial Hospital

Primary contact Tim Heinrich

Position Chief Financial Officer

Email Redacted

Office Phone 773-975-6806

Mobile Phone Redacted

Address 850 W. Irving Park Road, Chicago, IL 60613

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**List of entities participating in the collaboration:**Entity Name Thorek Andersonville (Methodist) HospitalPrimary contact Tim HeinrichPosition Chief Financial OfficerEmail **Redacted**Office Phone 773-975-6806Mobile Phone **Redacted**Address 5025 North Paulina Street, Chicago, IL, 60640

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**Project Description**

Does your collaboration include multiple, external, entities?

Yes ☒

No ☐

Can any of the entities in your collaboration bill Medicaid?

Yes ☒

No ☐

Based on your responses to the two questions above, your application meets basic eligibility criteria. You may proceed to complete the remainder of the application.

## 1. Participating Entities

### Contact Information for Collaborating Entities

1. What is the name of the lead entity of your collaborative? **The Loretto Hospital**

2. Please provide primary contact information, secondary contact information, and the Tax ID # of each entity in your collaborative. Please list the lead entity in the top row.

Entity Name	Tax ID # (xx-xxxxxxx)	Primary Contact	Position	Email	Office Phone	MobilePhone	Secondary Contact	Secondary Contact Position	Secondary Contact Email
The Loretto Hospital	Redacted	George Miller	President and CEO	Redacted	(773) 854-5000	Redacted	Nikhila Juvvadi	CCO/ VP Operations	Redacted
Roseland Community Hospital	Redacted	Robert Vais	CFO	Redacted	(773) 995-3044	Redacted	Elio Montenegro	Senior Director of Business Development	Redacted
Saint Anthony Hospital	Redacted	Randy Stein	Executive Director Revenue Cycle	Redacted	(773) 484-4807	Redacted	Bob Enkema	CFO	Redacted
South Shore Hospital	Redacted	Tim Caveney	President and CEO	Redacted	(773) 356-5200	Redacted	Donald McGruder	CIO	Redacted
St. Bernard Hospital	Redacted	Robert Springer	CFO	Redacted	(773) 962-4210	Redacted	Roland Abellera	COO	Redacted
Thorek Memorial Hospital	Redacted	Tim Heinrich	CFO	Redacted	(773) 975-6806	Redacted	Edward Budd	President and CEO	Redacted
Thorek Andersonville (Methodist) Hospital	Redacted	Tim Heinrich	CFO	Redacted	(773) 975-6806	Redacted	Edward Budd	President and CEO	Redacted

3. Please confirm that you have entered the required information for each entity in the table above, including secondary contact information and Tax ID #. ☒ I confirm

4. Please upload the most recent IRS Form 990 (including Schedule H, if applicable) for all participants in the collaboration. (Note: These 990s will all have to be compiled into a single PDF file.)

EHR Collaborative 990s\_COMBINED Final

Participating Entities

Please answer the following questions regarding the various entities that would comprise your collaborative.

1. Are there any primary or preventative care providers in your collaborative?

Yes ☒

No ☐

1A. Please enter the names of entities that provide primary or preventative care in your collaborative.

The Loretto Hospital  
Roseland Community Hospital  
Saint Anthony Hospital  
South Shore Hospital  
St. Bernard Hospital  
Thorek Memorial Hospital  
Thorek Andersonville (Methodist) Hospital

2. Are there any specialty care providers in your collaborative?

Yes ☒  
No ☐

2A. Please enter the names of entities that provide specialty care in your collaborative.

The Loretto Hospital  
Roseland Community Hospital  
Saint Anthony Hospital  
South Shore Hospital  
St. Bernard Hospital  
Thorek Memorial Hospital  
Thorek Andersonville (Methodist) Hospital

3. Are there any hospital services providers in your collaborative?

Yes ☒  
No ☐

3A. Please enter the name of the first entity that provides hospital services in your collaborative.

The Loretto Hospital

3B. Which MCO networks does this hospital participate in?

- ☒ YouthCare
- ☒ Blue Cross Blue Shield Community Health Plan
- ☒ CountyCare Health Plan (Cook County only)
- ☒ IlliniCare Health
- ☒ Meridian Health Plan (Former Youth in Care Only)
- ☒ Molina Healthcare

3C. Are there any other hospital providers in your collaborative?

Yes ☒  
No ☐

3D. Please give the name of your second hospital provider here.

Roseland Community Hospital

3E. Which MCO networks does this hospital participate in?

- ☒ YouthCare
- ☒ Blue Cross Blue Shield Community Health Plan
- ☒ CountyCare Health Plan (Cook County only)
- ☒ IlliniCare Health
- ☒ Meridian Health Plan (Former Youth in Care Only)
- ☒ Molina Healthcare

3F. Are there any other hospital providers in your collaborative?



Yes ☒  
No ☐

3G. Please give the name of your third hospital provider here.  
Saint Anthony Hospital

3H. Which MCO networks does this hospital participate in?

- ☒ YouthCare
- ☒ Blue Cross Blue Shield Community Health Plan
- ☒ CountyCare Health Plan (Cook County only)
- ☒ IlliniCare Health
- ☒ Meridian Health Plan (Former Youth in Care Only)
- ☒ Molina Healthcare

3I. Are there any other hospital providers in your collaborative?  
Yes ☒  
No ☐

3J. Please give the name of your fourth hospital provider here.  
South Shore Hospital

3K. Which MCO networks does this hospital participate in?

- ☒ YouthCare
- ☒ Blue Cross Blue Shield Community Health Plan
- ☒ CountyCare Health Plan (Cook County only)
- ☒ IlliniCare Health
- ☐ Meridian Health Plan (Former Youth in Care Only)
- ☐ Molina Healthcare

3L. Are there any other hospital providers in your collaborative?  
Yes ☒  
No ☐

3M. Please give the name of your fifth hospital provider here.  
St. Bernard Hospital

3N. Which MCO networks does this hospital participate in?

- ☒ YouthCare
- ☒ Blue Cross Blue Shield Community Health Plan
- ☒ CountyCare Health Plan (Cook County only)
- ☒ IlliniCare Health
- ☒ Meridian Health Plan (Former Youth in Care Only)
- ☒ Molina Healthcare

3O. If there are any other hospitals in your collaborative, please list them all here, together with a list of MCO networks which each participates in.

Thorek Memorial Hospital  
YouthCare  
Blue Cross Blue Shield Community Health Plan  
CountyCare Health Plan (Cook County only)  
IlliniCare Health  
Meridian Health Plan (Former Youth in Care Only)  
Molina Healthcare Health Plan

Thorek Andersonville (Methodist) Hospital  
YouthCare  
Blue Cross Blue Shield Community Health Plan  
CountyCare Health Plan (Cook County only)  
IlliniCare Health  
Meridian Health Plan (Former Youth in Care Only)  
Molina Healthcare Health Plan

4. Are there any mental health providers in your collaborative?

Yes ☒  
No ☐

4A. Please enter the names of entities that provide mental health services in your collaborative.

The Loretto Hospital  
Roseland Community Hospital  
Saint Anthony Hospital  
South Shore Hospital  
St. Bernard Hospital  
Thorek Memorial Hospital  
Thorek Andersonville (Methodist) Hospital

5. Are there any substance use disorder services providers in your collaborative?

Yes ☒  
No ☐

5A. Please enter the names of entities that provide substance abuse disorder services in your collaborative.

The Loretto Hospital  
Roseland Community Hospital  
Saint Anthony Hospital  
South Shore Hospital  
St. Bernard Hospital  
Thorek Memorial Hospital  
Thorek Andersonville (Methodist) Hospital

6. Are there any social determinants of health services providers in your collaborative?

Yes ☒  
No ☐

6A. Please enter the names of entities that provide social determinants of health services in your collaborative.

The Loretto Hospital  
Roseland Community Hospital  
Saint Anthony Hospital  
South Shore Hospital  
St. Bernard Hospital  
Thorek Memorial Hospital  
Thorek Andersonville (Methodist) Hospital

7. Are there any safety net or critical access hospitals in your collaborative?

Yes ☒  
No ☐

7A. Please list the names of the safety net and/or critical access hospitals in your collaborative.

The Loretto Hospital  
Roseland Community Hospital  
Saint Anthony Hospital  
South Shore Hospital  
St. Bernard Hospital  
Thorek Memorial Hospital  
Thorek Andersonville (Methodist) Hospital

8. Are there any entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that that are majorly controlled and managed by minorities?

Yes ☒  
No ☐

8A. Please list the names of the entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that that are majorly controlled and managed by minorities.

AFO Technology Group, LLC

9. Please list the Medicaid-eligible billers (firms that can bill Medicaid for services) in your collaborative, and the Medicaid ID for each.

Safety-net Hospital	Medicaid ID
The Loretto Hospital	Redacted
Roseland Community Hospital	Redacted
Saint Anthony Hospital	Redacted
South Shore Hospital	Redacted
St. Bernard Hospital	Redacted
Thorek Memorial Hospital	Redacted
Thorek Andersonville (Methodist) Hospital	Redacted

10. Below are high-level descriptions of project types that appeared in the Transformation funding statute. Check any that apply to your project; if none apply, please provide a brief description of what kind of entities comprise your collaboration. (This question is informational only and will not affect your eligibility).

- ☒ Safety Net Hospital Partnerships to Address Health Disparities
- ☐ Safety Net plus Larger Hospital Partnerships to Increase Specialty Care
- ☐ Hospital plus Other Provider Partnerships in Distressed Areas to Address Health Disparities (led By Critical Area Hospitals, Safety Net Hospitals or other hospitals in distressed communities)
- ☐ Critical Access Hospital Partnerships (anchored by Critical Area Hospitals, or with Critical Area Hospitals as significant partners)
- ☐ Cross-Provider Care Partnerships Led By Minority Providers, Vendors, or Not-For-Profit Organizations
- ☐ Workforce Development and Diversity Inclusion Collaborations
- ☐ Other

10A. If you checked, "Other," provide additional explanation here.

[10A. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

## 2. Project Description

### Brief Project Description

1. Provide an official name for your collaboration. NOTE: Please ensure that this name matches the name given in the "Application Name" field in the Project Information form at the beginning of the application.

**Safety-Net Hospital Electronic Health Record Partnership**

2. Provide a one to two sentence summary of your collaboration's overall goals.

The Safety Net Hospital Electronic Health Record Partnership (Partnership) brings shared IT resources, support, and knowledge together from seven safety net hospitals in Cook County with the highest health disparities in the state to provide comprehensive care coordination, population health management, identify and address health disparities and improving health outcomes organizations by procuring a modern, interoperable electronic health record (EHR) system. This technology is the essential foundation for all seven hospitals upon which transformation initiatives and activities are built.

### Detailed Project Description

Provide a narrative description of your overall project, explaining what makes it transformational.

**Specify your service area, identify the healthcare challenges it faces, and articulate your goals in addressing these challenges; explain your strategy and how it addresses the causes of these challenges, and lay out the expected timeframe for the project.**

**Describe any capital improvements, new interventions, delivery redesign, etc. Your narrative should explain the need for each significant item in your budget, clarifying how each connects to the overall goals and operations of the collaboration.**

Provide your narrative here:

The Safety Net Hospital Electronic Health Record Partnership (Partnership) is comprised of seven safety net hospitals that together, serve a high-volume of Medicaid-eligible and more than 385,000 Cook County patients: Roseland Community Hospital, South Shore Hospital, St. Anthony Hospital, St. Bernard Hospital, The Loretto Hospital, Thorek Memorial Hospital, and Thorek Andersonville (Methodist) Hospital.

Collectively, they bring shared IT resources, support, and knowledge together to procure and implement a modern, interoperable electronic health record (EHR) system in all partner hospitals. This EHR system is the essential foundation upon which transformation initiatives and activities are built. The core functionalities of an updated EHR are prerequisites for comprehensive care coordination, population health management, identifying and addressing health disparities and improving health outcomes.

As the *Transformation Data and Community Needs Report Chicago-South Side* concluded "Second, it's important to note that some communities are structurally disadvantaged from benefitting from the transformation model proposed here. Decades-long disinvestment, particularly in predominantly Black communities, has resulted in a lack of basic healthcare infrastructure including facilities that accept Medicaid. This situation means that any transformation activities will need to also include substantive investments to put healthcare structures in place before interventions can be piloted." (*Transformation Data and Community Needs Report Chicago-South Side: February 2021*, prepared for HFS by the University of Illinois at Chicago School of Public Health and Institute for Healthcare Delivery Design, p. 54.)

A February 2021 article published in the New England Journal of Medicine summarized the consequences of the lack of investment in Black communities this way “The systemic disinvestment in public and private sectors within segregated Black neighborhoods has resulted in under resourced facilities with fewer clinicians, which makes it difficult to recruit experienced and well-credentialed primary care providers and specialists and thereby affects access and utilization.” (How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities. The New England Journal of Medicine, February 25, 2021, <https://www.nejm.org/doi/full/10.1056/NEJMms2025396>)

This lack of investment has a similar impact on the hospitals in the Partnership. For example, continuously limited resources to fund adequate EHR systems hinders the Partners’ ability to hire and retain primary care and specialty providers. Even providers who are committed to working in under resourced communities are more likely to choose to work in hospitals that offer well-functioning EHR systems and timely access to data for their patients.

Without an updated EHR, our partner hospitals are also precluded from meaningful participation in transformation models and activities that include:

- Sharing data with and accessing data from other providers, particularly social service providers, because integration with our antiquated systems is too costly and technically challenging
- Capturing and reporting data needed to implement transformation models and demonstrate their impact
- Limits the ability to participate in value-based payment models, which require data exchange with payers, the ability to track performance on standard quality measures and detailed reporting

The goals of this project are to modernize the EHR systems for these seven safety-net hospitals and outpatient settings to enable participation in Medicaid transformation efforts, including integrated models of care across multiple service providers, addressing health disparities and providing Medicaid customers with whole person care to address the specific social determinants of health needs in our communities.

The proposed healthcare software platform, Meditech, to be implemented through this transformation project, will address the following objectives:

- Ensuring access to IT staff with current knowledge and training and provide opportunities for members of our own communities to serve in those jobs
- Improve financial sustainability by enabling compliance with Medicare promoting interoperability program requirements
- Ability to share data with health care providers and social service providers across our communities to improve care coordination and enable transformation
- Reducing total cost of vital technology systems
- Empowering Medicaid customers with access to their health information and the ability to engage with their care providers virtually
- Improving clinician satisfaction and ease of use to help safety net hospitals attract and retain high-performing and experienced physicians and nurses
- Enabling partner hospitals to participate in value-based payment arrangement with payers, share data securely with them, calculate and track performance on quality measures and report data in a timely, accurate and efficient manner
- Concurrently allow each Partner to have autonomy and personalization with the system build

The project consists of three main components:

- **\*Group pricing and collective, standardized implementation of Meditech- a modern, subscription based EHR system.** This approach which will minimize future investments in hardware and IT staff to maintain and continuously update the EHR and ensure that Medicaid customers benefit from the latest clinical innovations, comprehensive data and care coordination capabilities. By leveraging group pricing the Partnership was able to reduce the total cost of the EHR by 20% from what we would have been charged if we had not pooled our collective buying power.

- **Streamlined and centralized reporting of performance metrics and other analytics enabled by the new EHR system.** With all hospital partners using the same EHR we can develop one set of metrics for all hospitals and the same data configuration in the EHR solution, which will be transmitted to a centralized secure cloud. This approach will save time and resources associated with collecting data from disparate systems, minimize need for custom builds, and prevent the need for expensive and time-consuming data integration
- **Shared IT resources and subject matter expertise provided through a minority-owned enterprise, which will supply resources to multiple partners for implementation and maintenance support of their new EHR system.** This approach facilitates sharing hard-to-hire and retain technical resources among hospital partners and supports the training and development of additional IT resources needed to support the technology and data functions of our partner hospitals' participation in Medicaid transformation.

**\*Meditech Proposal** – Attachment A is Meditech's proposal that includes the comprehensive set of EHR solutions and services needed to automate, integrate, and optimize the full spectrum of the care delivery system at each of the seven hospitals. Inclusive in their proposal are subscription, optional consulting services, infrastructure updates and hardware/devices and hospital staffing required to implement the MEDITECH Expanse EHR Platform. This proposal includes a detailed description of the MEDITECH as a Service (MaaS™) solution as well as associated pricing and installation deployment schedule data. Each safety-net hospital as part of this Partnership, obtained its own estimate for the cost of purchasing a new EHR system, but the Meditech proposal is priced as a group purchase and discounted to reflect the large size of the Partnership.

[Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

Attachment A\_Meditech MaaS Proposal

### 3. Governance Structure

#### Structure and Processes

1. Please describe in detail the governance structure of your collaboration and explain how authority and responsibility will be distributed and shared. How will policies be formulated and priorities set?

Each of the seven safety-net hospital Partners will engage in a shared governance structure to bind HTC partnership as required by the Department. Additional Partners may not be elected, appointed, or removed from the Partnership.

#### Authority

Partners will use Robert's Rules of Order's parliamentary procedure to conduct business efficiently and predictably.

#### Committees

The Partnership will hold two standing committees, an Executive and a Governance Committee, which are permanently appointed to distribute and share the Partnership's responsibilities.

The Governance Committee shall be comprised of each Partner's chief executive officer, who may appoint a proxy with decision-making authority. At a minimum, there shall be 12 Governance Committees monthly meetings the first year, but additional Partnership meetings can be called by the co-chair upon a Partner's written request. Governance Committee meeting frequency will be determined at the end of the first project year with approval from HFS.

A quorum shall be a majority of the Partners (four or more) serving on the Governance Committee. The Governance Committee will have the authority and responsibility to:

- amend, altering or repeal the Binding Agreement
- develop, approve and enforce policies and procedures
- authorize the voluntary dissolution of the Partnership
- adopt a plan for the distribution of the assets of the Partnership
- ensure the Department's reporting requirements are completed and submitted

Each year, the Governance Committee shall appoint officers by majority vote to comprise the Executive Committee of to include:

- one co-chair
- one treasurer, and
- one secretary

The *Executive Committee* shall oversee and drive the Partnership's business, monitor the progress of stated objectives in the HTC application, ensure milestones and goals are being met, and report to the Governance Committee at regular meetings regarding the action taken by the Executive Committee.

The Executive Committee shall also be charged with reviewing policies, and other actions recommended by the Governance Committee and with managing budgets and resources. Meetings shall be held as needed and called by any Member who serves on the committee. A quorum shall be a majority of the Partners serving on the Executive Committee.

Both the executive committee and treasurer is responsible for reviewing and providing guidance on the Partnership's financial matters, assures internal controls, and financial analysis for the Partnership as follows:

- Oversee the Partnership's fiscal agent
- Ensure internal fiscal integrity measures and safeguards are in place, including the monitoring of transformation funds, and for the creation of sustainability strategies



- Ensure the Department funds are being distributed to Partners in a timely manner and for the Partnership's intended purpose
- Monthly review of revenue and expenditure, balance sheet, investments and other matters related to its continued solvency.
- Ensure that adequate policies and procedures are in place for optimal financial governance
- Ensure that an annual audit takes place if necessary or applicable. This may include the selection of an auditor and reviewing draft audit reports before they are signed off.

#### Sub-Committees

These are committees other than the standing committees and may be appointed from time to time by the Partnership for the purpose of performing specific tasks outside the scope of the standing committees. The Partnership may also stand Ad Hoc committees appointed by the Executive Committee to perform and complete reporting and other requirements from the Department. Each will consist of two or more Partners. No such sub-committee shall have the authority of the governance or executive committee. The co-chair shall have the responsibility for appointing the individuals who are to serve on any committee designated by the Partnership.

[1. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

#### Accountability

2. How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally, and with extensive participation from each participating entity? What methods will be used to enforce policy and procedure adherence?

Each Partner will sign a binding agreement approved by all Partners that includes responsibility for and agreement to the following:

1. responding and acting on the Department's requests
2. adhering to any Partnership policies and procedures developed
3. accountability to achieve the Partnership's said milestones and outcomes
4. maintaining respectful and inclusive relationships among Partners
5. acting ethically, prudently and legally in go-faith regarding the Partnership
6. actively engaging and dedicating employees to represent and participate on behalf of each Partner at each Partnership meeting (committee or otherwise) with decision-making authority

[2. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

#### New Legal Entity

3. Will a new umbrella legal entity be created as a result of your collaboration?

Yes ☐

No ☒

[3A. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

4. How will you ensure direct payments to providers within your collaboration are utilized for your proposed program's intended purpose? If the plan is to use a fiscal intermediary, please specify.

Upon notice of award, the Partnership will ensure internal fiscal integrity measure and safeguards to ensure the Department's directed payments are distributed and used for their intended purposes as stated in the application. As such, the Executive Committee will develop a fund distribution policy and corresponding procedure(s) to be approved by the Governance Committee.



The Partnership will determine a fiscal agent (either a Partner or third-party) who will oversee the following aspects of the Department funds awarded:

- Establish a Medicaid provider(s) to receive HFS directed payments on behalf of the Partnership upon approval from the Department
- Ensure directed payments received by the Partner(s) will be directed to the fiscal agent to distribute the funds according to the Plan's specifications and within a specified time frame
- A monthly reporting methodology will be developed by the Partnership to ensure the fiscal agent's accountability.

[4. Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

#### 4. Racial Equity

##### High-Level Narrative

A fundamental focus of healthcare transformation is racial equity. Please provide a high level description of how the design of your proposal incorporates racial equity. (Greater detail will be requested in the questions below.)

This project directly addresses racial equity given the population in Partnership's service area are predominately Black and Hispanic communities that markedly experience disparities, especially those with low incomes. The successful implementation of this project will directly reduce racial and health disparities that exist in Cook County by allowing the Partners to collect data that can be stratified by race, age, ethnicity, language, sexual orientation, and gender identity – which is fundamental to identify, assess, address, and measure outcomes that lead to race and health disparities.

[High Level Narrative - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

##### Racial Equity Impact Assessment Questions

##### 1. Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal?

General health status is suboptimal for resident living in the four priority service areas in Illinois (South Chicago, West Chicago, South Cook County, West Cook County), who also have the greatest concentration of social vulnerability to health inequities and poor health outcomes. These communities have also experienced disproportionately higher numbers of COVID-19 infections, hospitalizations, and deaths relative to other communities in Illinois. Table 1 shows the total population of the Partnership's service area, race and ethnicity, life expectancy, mean income, unemployment and poverty rates compared to the state and national numbers.

The service area has more than twice as many Black, and almost twice as many Latinos compared to the state and country. Life expectancy is more than five years less than that of residents in Illinois and the mean income is 2.75 times lower than the state and more than half the national average. Unemployment and poverty rates are almost double the national average.

Table 1: Service Area Demographics

	Service Area	Illinois	United States
Population	760,560	12,671,821	328,239,523
White (%)	47	71	76
Black (%)	33	14	13
Latino (%)	33	18	18
Life Expectancy	75	79	77
Mean Income (\$)	25,651	70,566	54,129
Unemployed (%)	11.4	7.2	5.9
Poverty Rate (%)	19.4	11.5	12.3

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
 (Note: if you wish to include multiple files, you must combine them into a single document.)

2. Have stakeholders from different racial/ethnic groups — especially those most adversely affected or from vulnerable communities — been informed, meaningfully involved and authentically represented in the development of this proposal? Who's missing and how can they be engaged?

Each partner hospital sought input from two primary stakeholders- patients and staff, by developing and conducting surveys, as well as input from elected officials. Patients are those most adversely affected and live in one of the five most socially vulnerable communities in Illinois, as outlined in HFS 2021 Transformation Data & Community Needs Report.

A total of 168 surveys were completed by patients to measure the importance of an easily accessible electronic medical record that allows them to view their health information from other providers in the event of an emergency and the value of accessing specific features such as lab results and medications, health history, information from office visits, X-rays and other medical images, provider notes, treatment plans, and notices about follow-ups. Table 2 below shows the racial and ethnic demographic breakdown of each hospital's patient populations. These percentages, however, are manually calculated (compromising accuracy) and can't routinely be tracked over time due to current EHR limitations.

Table 2: Partner Patient Demographics

	American Indian/Alaska Native	Asian	Black	Hispanic or Latino	Native Hawaiian/ Pacific Islander	2+ Races	White
The Loretto Hospital	0%	1-9%	70-79%	10-19%	0%	*	10-19%
Roseland Hospital	1-9%	1-9%	80-89%	10-19%	0%	*	1-9%
Saint Anthony	0%	1-9%	30-39%	50-59%	0%	1-9%	10-19%
South Shore	0%	0%	80-89%	1-9%	0%	1-9%	10-19%
St. Bernard	0%	1-9%	70-79%	10-19%	0%	1-9%	1-9%
Thorek/Methodist *		20-29%	20-29%	20-29%	*	1-9%	20-29%
<b>Average</b>	<b>0%</b>	<b>1-9%</b>	<b>60-69%</b>	<b>20-29%</b>	<b>0%</b>	<b>1-9%</b>	<b>10-19%</b>

*\*indicates no data available*

Each partner will continue to meaningfully involve and ensure the authentic representation of patient stakeholders during the EHR implementation process (to get input on certain patient functions/features) and post-implementation to promote features such as the patient portal and educate patients on how and why they should access their patient information. Additionally, Partners will maintain and assess the level, diversity, and quality of ongoing stakeholder engagement by conducting continued patient satisfaction surveys, monitoring of HEDIS measures, and continue their diversity and inclusion efforts.

The Partnership did not identify other stakeholders that are adversely or directly impacted by the EHR project.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
 (Note: if you wish to include multiple files, you must combine them into a single document.)

3. Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

Patients from zip codes the Partnership currently serves are over 65% Black, 25% Latino and 10% are two or more races- comprising approximately 90% of all patients. When it comes to health, Blacks and Latinos are currently the most disadvantaged groups and whites are advantaged due to various factors, including the complex issue of institutional racism. In addition to race and ethnicity, individuals who experience socioeconomic inequalities are also negatively impacted. When compared with whites, there are many disadvantages experienced by Blacks and Latinos that create health disparities across all facets of health that result in reduced life expectancy and reduced quality of life.

More specifically, years of data have shown some racial health disparities in patient portal adoption and use by people of color are less likely to use the health IT than their White counterparts.[1] They are likely to experience SDoH barriers as well as implicit bias in healthcare that has eroded patient trust, and income dictates whether a patient has access to a device to view a patient portal or broadband to support it.[2]

#### Quantitative and Qualitative Data

The 2021 HFS Transformation Data and Community Needs Reports guided the Partnership's planning efforts and provided a comprehensive and timely review of key data specific to the areas of highest need in Cook County, as well as Community Health Needs Assessments conducted by the Partners.

Partners however, cannot currently collect self-reported patient data accurately and consistently to identify the distinct health disparities experienced by patients at each hospital. Half do not have processes in place to collect, store, and maintain self-reported REaL patient data and five do not have processes in place to collect, store, and maintain self-reported SOGI patient data.

The following is a list of evidence the Partnership identified as missing to better inform the project and other locally coordinated HTC initiatives.

- Standardization of data collection including REaL and SOGI data
- Standardization of screening tools and assessments (SDoH, PHQ9, etc.)
- Sharing and standardization of local best practices
- Data sharing to facilitate integrated care plan development and track health outcomes and quality metrics

<https://patientengagementhit.com/news/4-sdoh-driving-health-disparities-in-patient-portal-use>

<https://patientengagementhit.com/news/lack-of-access-to-health-information-threatens-digital-divide>

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

4. What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

In addition to the inability to capture REAL and SOGI data, additional data interoperability factors perpetuate and exacerbate inequities as discussed in this project, include:

- Limited sharing of health care information among health plans, health care providers, and community-based organizations
- No state Medicaid claims data repository or a requirement for MCO's to share claims data with

providers in alternative payment models (APM)

- Care plans are duplicative, services are unnecessarily repeated, and medical errors are compounded
- An underdeveloped Health Information Exchange that does not share patient data on web-based platforms that are accessible to CBOs and social service organizations

[4 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

5. What does the proposal seek to accomplish? Will it reduce disparities or discrimination?

A recent report supported by the Robert Wood Johnson Foundation, the Center for Health Care Strategies (CHCS) and the Association of State and Territorial Health Officials (ASTHO) “led a national scan to identify health equity priorities that state agencies can advance in the next two years” and concluded that leveraging health data to advance health equity efforts was one of the three best ways to do so, as well as advancing internal-facing health equity work and meaningful community engagement. [3]

This proposal’s goal is to modernize the EHR systems does this by allowing partners to share data with health care providers and social service providers across the community to improve quality measures, participate in value-based payment arrangement with payers, and empower Medicaid patients with access to their health information and engage with their care provider teams.

Cross-Agency Partnerships for Health Equity: Understanding Opportunities Across Medicaid and Public Health Agencies

[5 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

6. What are negative or unforeseen consequences and positive impacts/opportunities for equity as a result of this proposal? Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts be prevented/minimized and equitable opportunities be maximized?

The digital divide and other varying SDoH factors can be negative or unforeseen barriers to patient information. A recent study conducted by the American Journal of Managed Care stated:

“...in 2017-2018, 54% of US adults reported having been offered access to OMRs [online medical records], and among those offered, 57% reported accessing their records. The groups who were less likely to be offered OMRs included men, middle-aged adults, members of racial/ethnic minority groups, individuals with lower education and household incomes, those who do not use the internet, and those living in rural areas. Respondents who were less likely to access their OMRs despite being offered included individuals with lower education and household incomes and rural residents. Like other aspects of medicine, patient portal use sees health disparities, and that’s largely because of inequities in access. In other words, not every patient has the same opportunity to make the most out of patient portal access.”[4]

Potential mitigation strategies can include training for providers, researchers, evaluators, and consumers of data on culturally responsive methodologies to drive the use of data in services of advancing health equity, as well as patient engagement strategies through patient engagement led by community health workers.

<https://www.ajmc.com/view/barriers-to-accessing-online-medical-records-in-the-united-states>

[6 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

7. Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

Racial disparities and advancing racial equity requires system-wide engagement and commitment, including that from MCO's who can be powerful collaborators with these Partners as part of this effort by:

- Leading efforts to ensure insurance coverage for individuals with low income and communities of color
- Serve as industry thought partners in health care payment and delivery, and how to use levers (e.g., value-based payment) to advance health equity
- Reimagine contracting strategies to leverage quality improvement for health equity
- Establishing and prioritizing mutual health equity goals and measuring progress

[7 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

8. Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement? Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

Reversing the long-standing and systemic inequities in Cook County will take more time and investment than is feasible within the current funding opportunity. The Partnership proposes to use funding to make substantial and sustainable improvements in the system of care by ensuring:

1. Accurate and methodological collection of REAL and SOGI data to identify and address health inequities
2. Improved interoperability with a common EHR will be employed to promote information exchange among the full care team
3. More detailed planning, including workflows that facilitate integration and model implementation, performance monitoring and iterative improvement

[8 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

9. What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

#### Success Indicators

The Partners will establish success indicators and progress benchmarks to document and evaluate the resulting EHR infrastructure and capacity improvements that align with HFS's goals. The Partners will establish baselines, track and report on indicators a minimum of four times a year once the EHR has been implemented. Reports of the following success indicators will be provided to the Department as directed:

1. Participation in population health initiatives
2. Utilization of chronic disease management tools
3. Integration of population health management solutions that enable targeted interventions to address the SDOH needs of sub-populations that are driving specific health disparities
4. Improvements in access to care (telehealth services, home monitoring, increased patient safety and satisfaction)
5. Improvements in effective care coordination (Patient empowerment and access to data)
6. Use EHR in conjunction with Health Choice Illinois ADT notifications to community providers
7. Increase and improve use of preventative care and screenings for SDOH
8. Managing patient data across care settings- allowing hospitals to address SDOH in collaboration with their local community-based organization and social service partners
9. Facilitating integrated care (physical and behavioral) through data sharing
10. Developing and using health equity performance measures
11. Increasing capacity to participate in advanced value-and outcome-based payment models
12. Streamlining and enhancing eligibility and enrollment procedures, data integration, and pharmacy management
13. Improving robust performance reporting
14. Monitoring performance on specific HEDIS measures in real time for populations served by our communities and specific subpopulations

As part of this measure, the Partners will maintain and assess the level, diversity, and quality of ongoing stakeholder engagement by conducting continued patient satisfaction surveys, monitoring of HEDIS measures, engage patients in program development and continue to build on strategic organization diversity and inclusion efforts.

[9 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

## 5. Community Input

### Service Area of the Proposed Intervention

1. Identify your service area in general terms (e.g., "West Chicago", "East St. Louis Metro Area", "Southeastern Illinois"). Cook County, West Chicago, South Chicago, West Cook, South Cook

:

2. Please select all Illinois counties that are in your service area. (NOTE: Selecting a county does not mean that your intervention must service the entire county.)

(Hold CTRL+click on a PC or command+click on a Mac to select multiple counties).

Select counties:

Cook

3. Please list all zip codes in your service area, separated by commas.

**West Chicago:** 60608, 60622, 60624, 60639, 60644, 60612, 60623, 60634, 60642, 60651

**South Chicago:** 60609, 60619, 60629, 60636, 60652, 60615, 60620, 60631, 60638, 60653, 60616, 60621, 60632, 60643, 60655, 60617, 60628, 60633, 60649

**South Cook:** 60406, 60429, 60456, 60466, 60478, 60409, 60430, 60457, 60467, 60480, 60411, 60438, 60458, 60469, 60482, 60415, 60439, 60459, 60471, 60487, 60419, 60443, 60461, 60472, 60501, 60422, 60445, 60462, 60473, 60803, 60425, 60452, 60463, 60475, 60805, 60426, 60453, 60464, 60476, 60827, 60428, 60455, 60465, 60477

**West Cook:** 60104, 60155, 60171, 60402, 60707, 60130, 60160, 60176, 60513, 60804, 60131, 60162, 60301, 60525, 60141, 60163, 60302, 60526, 60153, 60164, 60304, 60534, 60154, 60165, 60305, 60558

Community Input

1. Describe the process you have followed to seek input from your community and what community needs it highlighted.

All Partners engage with clinical champions, patients, and families, and/or community partners in at least one strategic and action planning activities to reducedisparities in health outcomes for all patient populations.

	Patient Advisory Board	Community Councils/Org Partnerships	Identify & Promote Community- based Asset Development	Community based participatory research	Partner on Quality of Life Plans
Loretto		X		X	X
Roseland		X	X	X	X
Saint Anthony		X	X	X	X
South Shore		X			
St. Bernard	X	X			X
Thorek		X	X		
Memorial					
Methodist		X	X		



Each partner hospital sought input from two primary stakeholders- patients and staff, by developing and conducting surveys, as well as input from elected officials.

## Patients

A total of 168 surveys were completed by patients to measure the importance of an easily accessible electronic medical record that allows them to view their health information from other providers in the event of an emergency and the value of accessing specific features such as lab results and medications, health history, information from office visits, X-rays and medical images, provider notes, treatment plans, and follow-up notices.

### Patient Findings

Over 85% of patients would prefer to have access to and view their medical record online. Of this group, 85% would like to see a new EHR allow them the ability to view their health history and every three out of four would like to view their personal lab results and prescribed medication, receive notices about follow-ups, access information about their office visits, and view medical images, includes X-rays. Additionally, more than 80% of those surveyed would like some version of a family member, primary doctor, or emergency care team to have access to their health information in both cases of emergency and during normal office visits.

## Staff

A total of 657 hospital staff from each Partner (320 administrative staff and 337 providers) completed a survey to understand the current functionality of their current EHR and improvements they would like to have. Two surveys, one for each group, were developed to capture information most relevant to their work.

### Staff Findings

An overwhelming 96% of all staff indicated the hospital would benefit from a new EHR. More than half of the administrative staff and 72% of providers indicated the EHR was either somewhat or not easy to understand. Administrative staff used the EHR's clinic module (34%), medical records (31%), data analytics (22%), revenue cycle/billing (21%), intake/registration (20%), and scheduling/referrals (11%). and providers use the EHR, respectively. Table 3 below shows the top five EHR improvements staff reported as high need.

Table 3: Top Five Key EHR Improvements

	Administration	Providers	Total
More user friendly, intuitive, and easy to use EHR	57%	73%	65%
Change to another newer and more updated EHR	33%	28%	31%
Improve software continuity and interoperability (across departments and with external agencies)	13%	30%	22%
Improve notes function	12%	23%	18%
Consistent and reliable functionality (no downtime, faster loading)	15%	14%	15%

2. Please upload any documentation of your community input process or findings here. (Note: if you wish to include multiple files, you must combine them into a single document.)

**EHR Collaborative Surveys\_COMBINED Final**

Input from Elected Officials

1. Did your collaborative consult elected officials as you developed your proposal?

Yes ☒

No ☐

1A. If you consulted Illinois federal or state legislators, please select all legislators whom you consulted.  
(Hold CTRL+click on a PC or command+click on a Mac to select multiple legislators).

Select legislators:

Collins, L. - Ill. Representative - 9th State Representative District, Lightford, K. - Ill. Senator - 4th State Senate District

1B. If you consulted local officials, please list their names and titles here.

Alderman Michael D. Rodriguez, 22nd ward

Cook County Commissioner Dennis Deer, 2<sup>nd</sup> district

[Input from Elected Officials - Optional] Please upload any documentation of support from or consultation with elected officials. (Note: if you wish to include multiple files, you must combine them into a single document.)

**EHR Collaborative Letters of Support\_COMBINED Final**

## 6. Data Support

### 1. Describe the data used to design your proposal and the methodology of collection.

The Partners used KLAS data that is used to measure industry standards for EHR performance. After a series of meeting and demonstrations with Meditech, which is rated Best in Klas Acute and Patient Accounting (Community Hospitals) for seven consecutive years, the Partners decided Meditech was the most sustainable investment that builds on their existing platform and maximizes a group purchasing option.

### 2. Attach the results of the data analyses used to design the project and any other relevant documentation. (Note: if you wish to include multiple files, you must combine them into a single document.)

#### EHR Collaborative Data Results Analysis\_COMBINED Final.docx

Findings from the analysis concluded the current software platform is inefficient for documentation and abstraction of the data. Also, acting on those barriers to access in care would require more robust integration with social services across the area that the current technology does not allow for.

Additionally, four out of six Partners do not have a systematic approach to assess and document patient barriers to access or SDoH. Table 4 below shows the current capabilities of each Partner's EHR, indicated as none, low (some), medium (regularly), High (utilized to full extent).

Table 4

	Inter- Department Data Sharing	Data Sharing with External Entities	REaL and SOGI Data Collection	SDoH Data Collection	Standardized Assessments & Screening Tools
Loretto	Low	Low	Low	Low	Low
Roseland	Low	Low	None	Low	Low
Saint Anthony	Medium	Low	Low	Low	Low
South Shore	Low	Low	Low	Low	Low
St. Bernard	Medium	Low	Low	Low	Medium
Thorek Memorial	Medium	Low	Low	Low	Medium
Thorek Memorial Andersonville (Methodist)	Medium	Low	Low	Low	Medium

These findings were used to develop scopes for each hospital that would be shared with the EHR software vendor for pricing, staffing, implementation, and software launch.

## 7. Health Equity and Outcomes

1. Name the specific healthcare disparities you are targeting in your service area, including by race and ethnicity. Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes.

### Identifying Health Disparities

The proposed EHR platform upgrade is critical as it will significantly improve functionality for the seven safety-net hospitals serving Cook County in communities that are experiencing the greatest health disparities. A modernized and robust health information system creates the foundation for all seven Partners to address health disparities and join healthcare transformation efforts in the community.

In alignment with the HFS Comprehensive Medical Programs Quality Strategy, the Partners will gain the ability to collect data and proactively use analytics to measure and monitor performance, drive decisions, and address health disparities.

To empower patients and encourage collaborative treatment plans, the EHR allows the Partners to communicate effectively within their facilities, with patients while they are in the community, and with outpatient and social service providers.

As important, is the collection of self-reported patient data such as REaL, SOGI, and barriers in access to care. Of the seven Partners, only two collect approximately 80% of self-reported REaL and SOGI patient data and one collects information about barriers in access to care. Table 2 below shows the racial and ethnic demographic breakdown of each hospital's patient populations. Of important note- this data was manually processed and cannot be routinely tracked overtime, compromising the integrity and comprehensiveness of the data.

**Table 2: Partner Patient Demographics**

	American Indian/Alaska Native	Asian	Black	Hispanic or Latino	Native Hawaiian/ Pacific Islander	2+ Races	White
The Loretto Hospital	0%	1-9%	70-79%	10-19%	0%	*	10-19%
Roseland Hospital	1-9%	1-9%	80-89%	10-19%	0%	*	1-9%
Saint Anthony	0%	1-9%	30-39%	50-59%	0%	1-9%	10-19%
South Shore	0%	0%	80-89%	1-9%	0%	1-9%	10-19%
St. Bernard	0%	1-9%	70-79%	10-19%	0%	1-9%	1-9%
Thorek/Methodist *		20-29%	20-29%	20-29%	*	1-9%	20-29%
<b>Average</b>	<b>0%</b>	<b>1-9%</b>	<b>60-69%</b>	<b>20-29%</b>	<b>0%</b>	<b>1-9%</b>	<b>10-19%</b>

*\*indicates no data available*

While the Partners have yet to identifying the disparities to address, once the new EHR is implemented, Partners will create baselines using REaL data. Given the extreme disproportionality of Black patients, Partners will prioritize the identification of and addressing specific health disparities of Black community.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
 (Note: if you wish to include multiple files, you must combine them into a single document.)

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

An EHR update supports community population health goals, patient safety, quality, care coordination. One tool is the patient portal, where patients can share their complete medical record among providers to ensure reliable continuity of care. A medical record includes demographic data, clinical history, hospital admissions, discharges, medications, lab tests and results, risk assessments, and care plans. When clinicians and other members of a patient's care team have access to this data, they can work collaboratively on care plans and make the best care decisions, communicate efficiently with patients and their caregivers, avoid unnecessary tests, procedures, and admissions, and improve health outcomes while reducing costs.

Partners will be able to set up a patient portal as one of the first activities to ensure to address health disparities by ensuring patients are empowered to access, understand, and work as partners with their providers to improve their health.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
 (Note: if you wish to include multiple files, you must combine them into a single document.)

### 3. Why will the activities you propose lead to the impact you intend to have?

As discussed above, the modernization of each Partners EHR will produce data in more standardized and useful formats that can be shared efficiently within the hospital, patients, HealthChoice Illinois ADT, and other health care and social service providers across our communities. The improved EHR functionality and data quality will support better care coordination, improve usability and functionality for shared physicians and other clinicians who work in multiple hospitals across the Partnership, reduce overall costs and enable targeted interventions.

In conjunction with the patient portal, these combined activities will lead to targeted interventions that address health conditions negatively and disproportionately impacting the Medicaid customers they serve.

Additionally, each Partner completed the Illinois Health and Hospital Association's 2021 Racial Equity in Healthcare Survey that was developed as a long-term accountability tool to document progress toward achieving racial health equity. The survey provided an opportunity for Partners to create a baseline self-assessment and then develop health equity goals, assess implementation of key strategies, understand provider and community assets in racial equity work, and identify areas of improvement.

As a guidance document, each Partner has respectively committed to the ongoing work and progress outlined in the survey, which includes equity categories and measures for internal (staff and leadership composition/training, data collection) and external efforts (community engagement, patient satisfaction).

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

## 8. Access to Care

1. Name the specific obstacles or barriers to healthcare access you are targeting in your service area. Describe the causes of these obstacles that your project specifically seeks to address and explain why you have chosen to address these causes.

Outdated EHR's currently used by the Partnership has created and exacerbated barriers to high-quality care for the communities being serve. The implementation of an updated and modernized HER as proposed in this project mitigates the following obstacles to access:

- Inability to conduct screenings and assessments in the EHR prevents clinicians from accessing timely and comprehensive information about the wholistic needs of patients
- Lack of access to medical history, prior utilization and diagnostic data from other hospitals and community providers causes unnecessary patient service delays and limits a clinicians' ability to make treatment decisions based on comprehensive information
- Inability to make electronic referrals to providers, services and supports in the community that improve patient health outcomes
- Lack of coordinated and timely sharing of information with community providers to coordinate care and services that address the SDoH
- Limited functionality, usability (ease of use), and unreliability make recruiting high-performing and specialty clinicians more challenging
- Inability to support telehealth and patient portals for care options routinely available in other hospitals and more affluent communities

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

1. *Inability to conduct screenings and assessments in the EHR prevents clinicians from accessing timely and comprehensive information about the wholistic needs of patients:* The new EHR system will enable administrative and clinical staff to complete standardized assessments and screening tools that identify needs for both health care and social services, and drive scheduling of preventive care and referrals to primary and specialty care that address the wholistic health condition and SDoH needs of patients.
2. *Lack of access to medical history, prior utilization and diagnostic data from other hospitals and community providers causes unnecessary patient service delays and limits a clinicians' ability to make treatment decisions based on comprehensive information:* The new EHR will enable the clinical teams to quickly access relevant medical history, current medication, diagnostic results, and recent utilization data from external providers, which help clinicians determine and deliver the most appropriate care quickly. The new system also enables seamless sharing of records with any other providers that are connected to CommonWell, a national network that allows thousands of providers and hospitals to exchange data securely and efficiently.
3. *Inability to make electronic referrals to providers, services and supports in the community that improve patient health outcomes:* The referral module in the new EHR enables electronic referrals to a broad range of providers who can address patient needs identified through standardized assessments and screenings and connect them to post-discharge services for recovery and health maintenance after an inpatient stay or visit to the emergency room. This new functionality allows hospitals to electronically search directories of community and social service providers to help patients access services such as food and nutritional programs, housing, transportation, and employment assistance.

4. *Lack of coordinated and timely sharing of information with community providers to coordinate care and services that address the SDoH:* Unlike the updated EHR systems in most acute care hospitals, the current EHR systems used by the Partners do not have built-in data exchange modules. Individual data interfaces between systems is needed to exchange patient information between inpatient and outpatient settings or with external providers. These interfaces are time-consuming, costly, and inefficient. The data exchange module in the new EHR allows application programming interface (API) access to external systems, including health information exchanges. This will allow our hospitals to share information securely and timely with other clinical providers to improve care coordination.
5. *Limited functionality, usability (ease of use), and unreliability make recruiting high-performing and specialty clinicians more challenging:* As noted in the Partnership's staff survey results, the current EHR systems do not have the advanced functionality of systems for physicians and nurses, which they have used in other hospitals. Clinicians who are trained at academic medical centers and have had the benefit of working on state-of-the-art systems are less likely to choose to work in settings with outdated technology- further challenging recruitment and retention efforts. The new EHR system we have selected for this project received high user-satisfaction scores among community hospitals and has received highly favorable ratings for nursing usability. The new EHR system also includes a mobile option that allows clinicians secure access from any location.
6. *Inability to support telehealth and patient portals for care options routinely available in other hospitals and more affluent communities:* The current EHR systems does not support easy-to use telehealth services or patient portals. These technology limitations restricted the ability to offer telehealth services during public emergencies like the COVID-19 pandemic, which resulted in significant, avoidable delays in care for the communities served. The new EHR system supports telehealth services that allow clinicians to connect with patients in their environment. The patient portal is accessible through mobile phones to afford patients the ability to communicate with their clinicians and access information to manage their health.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

### 3. Why will the activities you propose lead to the impact you intend to have?

The activities we propose, using modernized EHR features and functions described above, will help the Partnership positively impact health care access, equity and quality in the communities. We are confident of this positive impact because these kinds of technology systems have enabled similar benefits in other hospitals across the state and country. The benefits of this new system: integrated screening and assessment tools, seamless referral capability, interoperable data exchange with other providers, advanced clinical workflows, patient registries and support for telehealth, are all routinely available at non-safety net hospitals and have led to improvements in quality measures and patient outcomes.

Extensive discussions with Meditech, the EHR vendor, have been had to review case studies of other hospitals that use their product in the ways proposed in this project. These hospitals have achieved measurable improvements in areas like reducing hypertension, improving rates of behavioral health screening and interventions, and making successful referrals to community-based providers who are able to meet patients ongoing needs after discharge.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)



## 9. Social Determinants of Health

1. Name the specific social determinants of health you are targeting in your service area. Describe the causes of these social determinants that your project specifically seeks to address and explain why you have chosen to address these causes.

Clinicians from each Partner hospital can use social determinants of health (SDoH) information to create new strategies for patient data access close the gap on patient engagement, something that is critical for closing overall health disparities and building toward health equity.

Currently, four partners do not have a systematic approach to assess and document barriers in access and only one measures SDoH (one is in the early stages of development). Without these capabilities, the Partners cannot determine the specific SDoH to be targeted in the service area or their causes.

The Meditech platform supports the efforts of safety net hospitals to provide equitable care for the residents of Chicago's West and South Sides who have experienced health disparities ranging from materially higher disease incidence to comorbidities that significantly lower life expectancy. Health Equity and attention to SDOH are keys to providing care and achieving outcomes in these underserved communities. Important to this effort is collecting, reporting, and identifying what patients need to achieve improved health outcomes.

The Partnership will use this technology to transform care with a single-database, interoperable and financially sustainable solution, as well as additional benefits including:

- Access to the same clinical content to track benchmarks and KPIs
- Capabilities for population health management and patient care enhancements
- The ability for Partners to share templates and reports for standardization across the communities served.

As an example, the Loretto Hospital prioritized supporting patients with the resolution of health-harming living and housing conditions. In the Austin Community, numerous patients suffer injustice and poor health outcomes as a result of unmet legal needs. Loretto Hospital partnered with Lawyers' Committee for Better Housing (LCBH), a nonprofit law firm and community-based housing organization that integrates legal representation and advocacy into a patient's medical treatment program. The partnership is referred to as a medical-legal partnership and the purpose is to offer a better continuum of care for patients by providing free legal assistance to address serious housing issues that negatively impact a patient's health. "Support for housing as a critical SDOH can be expanded through a more efficient and convenient referral process," said Dr. Nikhila Juvvadi, the Loretto's Chief Clinical Officer/VP of Operations.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

Two Safety Net Hospitals have piloted, but not fully implemented or standardized a process to refer patients with an identified SDoH need to social support organizations. Two Safety Net Hospitals have piloted, but not fully implemented or standardized a process to refer patients with an identified SDoH need to social support organizations.

The ability to provide referrals to community-based organizations that address the SDoH can lead to innovative programs such as St. Anthony Hospital has a Community Wellness Department (CWD) that provides case management and health/public benefits navigation. They receive referrals from other Saint Anthony Hospital departments through the Continuing Care initiative and issues referrals to social support agencies. Continuing Care will consult with either our Case Management supervisor or Health Access supervisor depending on the clients' needs. If it is determined that the need or needs can be addressed through the CWD, Continuing Care will fill out an intake form, submit it to the appropriate CWD program supervisor and they will assign a case manager or health educator to the client. These clients would receive services, support and referrals to outside agencies as appropriate. Alternately, if it is determined that the need must be addressed outside of the hospital, the CWD will recommend agencies that can address the clients' needs. In this case, Continuing Care will issue the referral directly to the client. Finally, the CWD is a hospital department that receives referrals from outside agencies and offers free mental health therapy and family support, as well as case management and health navigation. Among the services provided in each of these programs are referrals to outside social support organizations.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

3. Why will the activities you propose lead to the impact you intend to have?

Partners will utilize the EHR integration function to ensure the collection and aggregation of SDoH data collected through patient registration, as well as integrating the information in a customizable digital format for clinical data analytics. The Partners will analyze the data identify health disparities, develop baselines and monitor progress.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

## 10. Care Integration and Coordination

1. Describe how your proposal improves the integration, efficiency, and coordination of care across provider types and levels of care.

All safety-net hospitals have a critical role in collaborating with other health care and social services organizations in the community, with MCO's and with HFS to effectively coordinate care for our patients. As we evaluate how the hospitals can more effectively perform this role, systems and workflows must be modified to enable effective care coordination. The Partnership is enthusiastically participating in the HealthChoice Illinois ADT project and is committed to working with HFS and MCO's to use ADT data for improved care coordination across different providers and levels of care.

It is important to note, however, that the hospitals routinely encounter barriers to sharing data between the inpatient and outpatient settings *within their own institutions*, making effective care coordination within each hospital challenging. This is another example of how the lack of investment in infrastructure results in health disparities and makes it increasingly more difficult to engage in transformative practices. The new EHR system provides seamless integration between inpatient and outpatient services and easy-to-navigate views of the demographic, clinical and administrative data in each patient's record, enabling a high-quality experience of care for patients.

## Coordinating Care Across the Continuum

The proposed new EHR includes a fully interoperable data exchange platform that will allow the hospitals to connect efficiently through standard application programming interfaces (API) and eliminate the barrier of costly and inefficient system-by-system data integrations. The interoperability is a built-in function and does not require custom configuration or engage additional technical resources.

Most of the primary, behavioral health, skilled nursing and specialty care providers in the community use different EHR's that are not integrated with each hospital, and with which their current EHRs cannot easily integrate. The interoperability solution in the new EHR can securely share patient summaries, discharge instructions, and referrals that can be consumed electronically by providers to coordinate patient care. Conversely, community providers can electronically send lab orders, radiology and other common procedures directly from their EHR systems, and receive notifications that the orders have been completed. This reduces the time it takes to deliver needed services to patients, but prevents unnecessary delays in care that occur with phone and fax communications and eliminates redundant services that can occur when lab and radiology results are not available to clinicians at the time they are treating a patient. In addition to sharing patient summaries of care and discharge summaries with community providers, information can be shared directly with patients and their caregivers through the patient portal, allowing them to stay informed of care decisions and empowering them to help manage their health conditions.

Similarly, the new EHR will enable the Partnership to share more comprehensive clinical information along with the electronic referrals, which will help providers receiving the referrals to make better informed clinical decisions and improve the experience of care and outcomes for our patients. Many of the staff we surveyed indicated that improved interoperability across different areas of the hospital and with partner organizations is an important reason why an upgraded EHR system is so necessary.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

2. Do you plan to hire community health workers or care coordinators as part of your intervention?

Yes ☐

No ☒

[2A - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

3. Are there any managed care organizations in your collaborative?

Yes ☐

No ☒

3A. If no, do you plan to integrate and work with managed care organizations?

Yes ☒

No ☐

3B. Please describe your collaborative's plans to work with managed care organizations.

Coordinating care with managed care organizations

Our current EHR systems make it very difficult to share data electronically with external entities, including managed care organizations. These data sharing challenges have in turn, significantly limited the ability to participate in care coordination activities, quality improvement initiatives and value-based payment arrangements with MCO's that many other hospitals with updated EHRs can participate in. We have engaged in discussions with Meridian about our plans to implement new EHR systems and the opportunities we will have to exchange data more effectively with them. The new functionality allows the hospitals to receive data from the managed care plans and integrate it into their systems to more quickly address the individual needs of new patients, share screening information with the plans to better assess treatment needs, and communicate with the plans in a timely manner when services on an individual member's care plan have been delivered.

The new EHR system also allows for the tracking and reporting of standard quality metrics that are a key focus of HFS' Quality Strategy and for which the managed care plans are accountable in their contracts. This new functionality gives way to participation in value-based payment arrangements in which the hospitals can play a more active and collaborative role with MCO's in ensuring, for example, that patients are receiving appropriate care following discharge from the emergency department or an inpatient stay. The new system also allow us to accurately document and report specific activities critical to value-based payment contracts, track them over time, and produce reports and analytics that hospitals can use to enhance our participation in more complex alternative payment models over time.

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

## 11. Minority Participation

1. Please provide a list of entities that will be a part of your collaboration/partnership that are certified by the Illinois Business Enterprise Program (BEP) and/or not-for-profit entities majorly controlled and managed by minorities that will be used on the project as subcontractors or equity partners.

**Note on BEP partners/vendors:**

***If one of the members of your collaboration already contracts with a BEP-certified firm or a not-for-profit entity that is majorly controlled and managed by minorities, only include the services of the firm that will be used on this project. To be included, these services must increase the entity's volume of work above the level of services already provided to the collaborating member.***

Resource to help you search for/identify BEP-certified vendors in Illinois:

***If you are seeking BEP-certified entities to partner/collaborate with, you may consult our resource guide linked below on How to Look Up BEP- Certified Vendors in the State of Illinois.***

Download resource:

How to Look Up BEP-Certified Vendors in the State of Illinois.pdf [List entities here:](#)

[Business Enterprise Program \(BEP\)](#) AFO Technology Group

The Partnership has established a relationship with a BEP vendor, AFO Technology Group, with whom we will partner to hire, train and retain a pool of information technology resources that will be deployed by multiple hospitals in the Partnership. AFO specializes in providing technology solutions and services that help agencies and firms improve productivity as they shift to more citizen-centric models and reduce costs to meet their growing budget constraints. AFO will support the centralized collection from each hospital partner's instance of Meditech Expanse into Meditech's cloud environment to enable reporting of performance metrics and other analytics on behalf of the Partnership as a whole. This will includes tasks such as: configuring the data repository; completing the required dictionary build and reconciliation process in Test and Live; building risk assessments which identify health disparities and incorporating SDOH questions; configuring patient portal to collect SDOH information directly from patient; building registries to identify patients and target specific populations of focus identified by the Partnership in their application; and creating a basic reporting tool to capture required data that can be transmitted to HFS.

### Equity Partners

Members of the Partnership are a diverse group of executive leaders representing various communities of Cook County. The list of members below are not-for-profit providers or community-based organizations that are majorly controlled and managed by minorities. These organizations will participate in the implementation and ongoing operation of the Partnership's transformed delivery system.

The Loretto Hospital

As a not-for-profit, community-focused health care provider, The Loretto Hospital offers a unique, patient-centered healthcare delivery system that promotes general wellness and education in the communities they serve. Serving more than 33,000 patients each year, the Loretto Hospital provides quality healthcare services including: primary care, geriatric medicine, vision care, behavioral health services, women's health, podiatric medicine, and dental services. In addition, they are the largest non-governmental employer in the Austin community with more than 600 employees many of whom live in Austin. Through partnerships with physicians, research institutions, area residents and local businesses, they strive daily to be their communities' health care provider of choice, dedicated to improving the health and well-being of the communities they serve.

### Roseland Community Hospital

For almost 100 years, Roseland Community Hospital has provided comprehensive healthcare services as a nonprofit corporation to residents of Chicago's far South Side neighborhoods. Its mission is to provide high-quality healthcare services to the residents of Roseland and surrounding community areas through philanthropic innovation and charitable resources that enhance Roseland Hospital. Roseland Hospital has maintained this strategic focus, despite a myriad of social, economic and political changes that dramatically affected the neighborhoods they serve. Ultimately, Roseland Community Hospital is a stellar example of a community hospital that is both owned and operated by the people that it serves. Through a vision to develop quality hospital programs and services that enable Roseland community residents to grow and live healthy lifestyles, Roseland acts as the community's integrated and coordinated healthcare choice, where professional caregivers provide quality services on the path to recovery and overall wellness.

### Saint Anthony Hospital

Saint Anthony Hospital is an independent, nonprofit, faith-based, acute care, community hospital dedicated to improving the health and wellness of the families on the West Side and Southwest Side of Chicago. From specialties such as maternity services, pediatrics, family medicine, behavioral health, dialysis, community wellness, and rehabilitation services, Saint Anthony offers quality services close to home, caring for people regardless of their nationality, religious affiliation, and ability to pay. Over time, Saint Anthony has grown to provide medical care, social services, and community outreach to the residents of several city neighborhoods, including: Little Village, North Lawndale, Brighton Park, Garfield Park, Back of the Yards, McKinley Park, Archer Heights, Pilsen, Austin, and Chinatown, as well as suburban Cicero. Ultimately, Saint Anthony is a community hospital, a community-centric institution, and a forward-thinking organization that addresses the challenges families face in their community and develop new models for community care that lead to the overall success of the community.

### South Shore Hospital

South Shore Hospital is an independent general acute care hospital that has been in existence since 1912. The hospital is currently staffed at a level of 135 beds with licensing for up to 170 beds. In addition, they have five primary care outreach facilities. South Shore employs over 470, including a medical staff of approximately 104 physicians and provides the following inpatient and outpatient services: respiratory care, physical therapy, surgery, nuclear medicine, radiology, laboratory, vascular, diagnostics, pharmacy, non-invasive cardiology, detox services, chemical dependency, transportation, wound and skin care, emergency medicine, geriatric psychiatry, HIV/AIDS services, and gynecological services. As a not-for-profit community organization located in the South Shore community area of Chicago, South Shore exists to provide the safest, highest quality healthcare experience possible to their patients and their families. Their vision is to be recognized as a compassionate healthcare provider dedicated to personal, clinical, and technological excellence. They strive to be the clear first choice in their surrounding communities for healthcare services through continuous improvement in our delivery system. South Shore's service area encompasses 17 community areas in the City of Chicago with an estimated population of 411,148 individuals.

### St. Bernard Hospital

A Roman Catholic facility founded by the Religious Hospitallers of St. Joseph and sponsored by Catholic Health International, St. Bernard Hospital and HealthCare Center aspires to live the healing mission of Christ within the South Side community of Chicago. That mission calls them to care for the sick and promote the health of the residents in the community while witnessing the Christian values of respect, dignity, caring and compassion for all persons. In all matters, St. Bernard Hospital and Health Care Center shows a special sensitivity to the culture of the people they serve and the special needs of the poor and powerless. Moreover, through a commitment to achieve health equity, St. Bernard is dedicated to building just and right relationships in the communities they serve and advocating change to end health disparities and systemic racism.

2. Please describe the respective role of each of the entities listed above, and specify whether they will have a role only during the implementation of your proposal or if they will have a role in the ongoing operation of your transformed delivery system.

The Loretto Hospital, Roseland Community Hospital, Saint Anthony Hospital, South Shore Hospital, and St. Bernard Hospital will all act as equity partners during the ongoing operation of this collaboration's transformed delivery system. The Loretto Hospital, Roseland Community Hospital, and Saint Anthony Hospital are equity partners that are not-for-profit entities majorly controlled and managed by minorities. South Shore Hospital and St. Bernard Hospital are not-for-profit entities that are majorly controlled by minorities, yet not managed. Both entities have Executive Leadership Teams in which minority participation represents exactly 50% of the group's makeup. AFO Group, as a BEP vendor, will only have a role with the Partnership during the implementation of the Partnership's proposal.

[2 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)



## 12. Jobs

### Existing Employees

1. For collaborating providers, please provide data on the number of existing employees delineated by job category, including the zip codes of the employees' residence and benchmarks for the continued maintenance and improvement of these job levels.

See attachment B of employee listings from each hospital.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

**Attachment B\_EHR Collaborative Employee Listings COMBINED Final**

### New Employment Opportunities

2. Please estimate the number of new employees that will be hired over the duration of your proposal. **0**

3. Describe any new employment opportunities in the future alignment of your proposal and how those opportunities reflect the community you serve.

**Not applicable. This project does not require any of the Partners to hire new employees.**

[3 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)

4. Please describe any planned activities for workforce development in the project.

**Not applicable**

[4 - Optional] Please upload any documentation or visuals you wish to submit in support of your response.  
(Note: if you wish to include multiple files, you must combine them into a single document.)



### 13. Quality Metrics

Alignment with HFS Quality Pillars

*In order to complete this section, you will need to reference the HFS Quality Strategy document linked below.*

HFS Quality Strategy:

<https://www.illinois.gov/hfs/SiteCollectionDocuments/IL20212024ComprehensiveMedicalProgramsQualityStrategyD1.pdf>

1. Tell us how your proposal aligns with the pillars and the overall vision for improvement in the Department's Quality Strategy.

Our project aligns directly with the HFS Quality Strategy Pillars as follows:

The new EHR system will enable standardized clinical functionality and documentation across the partners to improve data quality and integrity. By implementing an updated EHR system, the hospitals will be able to reliably and consistently perform tasks and workflows that support the Quality Strategy Pillars, then capture and report data to calculate clinical quality measures in a standard format, so they can be aggregated to a centralized data repository that can be leveraged for continuous clinical quality improvement.

Our BEP partner will provide the technical resources to work with our EHR vendor and solution to standardize data across all hospitals in the Partnership, collect the data into a central location, and create a set of standard reports for project reporting, quality measurement and performance improvement.

Using standard queries and reporting formats, the partners will measure and track progress on the following quality metrics to measure the impact of using the enhanced functions and features of the updated EHR system on key transformation pillars.

Once the new EHR system has been implemented at all hospitals and the quality metrics identified below have been configured for standardized calculation, collection and reporting, the Partnership will conduct an initial data collection period to identify the baseline performance on all identified quality measures that we intend to track for the remainder of the project period. It is anticipated that this baseline data collection period will occur in year two and we will begin reporting ongoing performance on key quality metrics against baselines and targets at regular intervals by the end of the second year of the project period.

[1 - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

2. Does your proposal align with any of the following Pillars of Improvement?

2A. Maternal and Child Health?

Yes ☒  
No ☐

Maternal and Child Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

**Pillar: Improve Maternal and Infant Health Outcomes**

Expectant mothers who do not have an established relationship with any of our clinicians or with an obstetrician often present at our emergency departments in labor. For the two hospitals in the Partnership that offer labor and delivery services, they need to be able to access any available records that can help the delivery team better understand the mother's individual health needs and conditions and help improve outcomes for the women in labor and their newborns. The new EHR system will allow our hospitals' clinical teams to search and retrieve records from other health care providers that participate in the Carequality information exchange network, in which participation is expected to grow every year as more providers are meeting CMS requirements for interoperability.

For the Partnership's hospitals that do not offer labor and delivery services, the new EHR system allows them to seamlessly refer and immediately transfer information for patients to other hospitals that do. This will help patients get access to the care they need faster and improve outcomes for women and their newborns. Additionally, the new EHR system's labor and delivery and ambulatory module will allow them to monitor both mother and baby from conception to birth and includes clinical best practices pediatric content. The new EHR's patient portal will enable providers and mothers in constant contact throughout pregnancy and beyond.

The new EHR system allows all hospitals in the Partnership to build patient registries to identify expectant mothers who arrive in the emergency department, facilitating seamless access to records among the Partnership hospitals. These registries can be shared amongst the hospitals and utilized for proactive monitoring, case management and referrals to partners that offer labor and delivery services for seamless transfer of care.

**Data Collection and Reporting**

Because only two of the seven hospital partners provide obstetric services, the Partnership will not collect and report on a maternal and child health metric.

The two hospitals, Roseland and St. Anthony, that currently provide obstetric services, however, will be able to use clinical decision support tools in the new EHR system that improve performance on the HEDIS Prenatal and Postpartum Care (PPC) measure, both the Timeliness of Prenatal Care and Postpartum Care components. Roseland and St. Anthony will track and report performance on the PCC measure and achieve improvement throughout the project period.

Hospital in the Partnership that do not provide obstetric services, will be able to use the new EHR to share data electronically more quickly and seamlessly with ambulatory providers and managed care plans when one of their patients who is pregnant or has recently delivered visits the emergency department or has an inpatient stay unrelated to her pregnancy. We expect this will positively impact improved performance on the PCC quality measure.

[Maternal and Child Health - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

**2B. Adult Behavioral Health?**Yes ☒No ☐

Adult Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

**Pillar: Improve Behavioral Health Services and Supports for Adults**

Adults with significant behavioral health needs often present in the emergency departments of partner hospitals and often do not have an established relationship with a clinician or a community behavioral health organization that can meet their ongoing behavioral health needs. It is not uncommon for these adults to present in the emergency department with symptoms that are initially recorded as physician health issues, but after examination are later determined to have a co-occurring or primary diagnosis that is related to a behavioral health condition. The new EHR system allows the Partnership's hospitals to serve these patients better, using the new EHR's integrated, specialized content and workflow for patients with behavioral health needs and help deliver the most appropriate clinical services and facilitate referrals to other providers for follow up care. The new system's advanced behavioral health care and treatment plan functionality helps the patient and caregivers navigate post-discharge services and referrals to community treatment.

The new EHR system also includes rules-based surveillance capabilities help clinicians monitor at-risk clients (e.g., at risk for suicide or violence, require use of seclusion or restraints) and the capability to develop behavioral health registries and screening tools that the Partnership's hospital partners will use to identify patients at risk of, for example, depression, post-traumatic stress, and substance use disorder.

### Data Collection and Reporting

The new EHR system will allow all hospitals in the Partnership to begin calculating and tracking the number of visits to the Emergency Department for BH Services that Result in Hospitalization and identify opportunities for improvement in this measure by the end of project year two.

All hospitals in the Partnership will be able to use the new EHR system's specialized content and workflows that are designed to support collaborative care teams and address patients' behavioral health needs. These workflows include coordinating clinical care related short-term outpatient services, inpatient hospitalizations, rehabilitative outpatient therapies, and residential treatment services. The new EHR will allow us to integrate standardized screening tools to identify behavioral health needs and interventions quickly and the referral capability will allow us to connect patients to the outpatient and community-based services they need to avoid return trips to the emergency department.

For patients that do require inpatient services, the new EHR provides advanced behavioral health care and treatment plan functionality, allows teams to document strengths, problems, and long-term goals, and perform group therapy reviews and psychiatric evaluations. Unlike current systems, which cannot be configured to incorporate new clinical information into decisions and workflows, the rules-based surveillance capabilities in the new EHR help clinicians monitor at-risk clients (e.g., at risk for suicide or violence, require use of seclusion or restraints) based on recent screenings, tests and utilized services.

Our hospitals will be able to develop specific behavioral health registries and toolkits to identify patients at risk of depression, post-traumatic stress, abuse, and addiction, which we will be able to begin using in project year two. These registries will be accessible to all Partners, along with all clinical documentation available for an individual patient and care plan documentation to assist in getting the patient connected to the most appropriate services to address their behavioral health needs.

The new EHR will allow us to improve performance on the HEDIS Follow up after hospitalization for mental illness (FUH) and follow up after hospitalization for alcohol or other drug use or dependence (FUA) measures, through the decision support tools, behavioral health care plan functionality, ability to make referrals for outpatient services, and measure tracking and reporting capability. All hospitals in the collaborative will report on this measure and achieve improvement throughout the project period.

In addition, the new EHR will allow ongoing communication with our patients after they are discharged from the emergency department or an inpatient stay, sending them electronic reminders and timely information to help them keep their follow up appointments.

[Adult Behavioral Health - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

#### 2C. Child Behavioral Health?

Yes ☐  
No ☒

[Child Behavioral Health - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

#### 2D. Equity?

Yes ☒  
No ☐

Equity: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

The Partnership serves communities with significant health disparities in Chicago and Cook County. The patient demographic data collection and analytics capabilities in the current EHR systems are limited and hinder the ability to measure the disease prevalence for specific conditions by racial, ethnic, or other sub-groups. This limitation makes it impossible to develop the needed data-driven interventions to address health disparities.

The new EHR system will allow hospitals to build registries that track and report disease prevalence for multiple demographic groups that allow us to identify the areas that need the most intervention to address health equity. We will also be able to use the clinical decision support tools to increase the rate of breast cancer screening and cervical cancer screenings for the patients we serve, and we will be able to use the EHR's quality measurement and reporting capability to track and report our progress on those screening measures over time.

[Equity - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

## 2E. Community-Based Services and Supports?

Yes ☒  
No ☐

Community-Based Services and Supports: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.

The new EHR system has a referral management function that can easily make and track referrals to other healthcare providers and securely send patient records to make referrals easy to navigate. Each hospital will be able to track and report the number of referrals by category of service and compare the data to the results of screenings and assessments to help determine where community-based service referrals need to be focused, both geographically and by service type.

[Community-Based Services and Supports - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

## 3. Will you be using any metrics not found in the quality strategy?

Yes ☐  
No ☒

[3A - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

## 14. Milestones

For all activities described in your proposal, please provide a calendar of milestones to show progress (e.g., when IT will be purchased, when IT will be operative, when construction projects will begin and end, when people will be hired, etc.) The timeline should be in months from award.

The following is a list of milestones and activities for the first, second, and third year of the Collaborative. Year one includes a calendar of milestones by month in two parts

- planning and infrastructure and implementation.
- Milestones for years two and three are calendared quarterly.

Planning, Infrastructure	Year 1					
	M1	M2	M3	M4	M5	M6
<b>Planning</b>						
Stakeholder Notification	X	X	X			
Establish Meetings with HFS	X					
Establish Governance Committee and Subcommittees	X					
Establish and Execute Binding Agreement and Policies	X					
Engage MCO's	X	X	X			
Partners Execute Meditech Contracts	X					
Sustainability Planning		X	X	X		
Meditech Demonstrations	X	X	X			
Meditech Data Gathering	X	X	X			
Month Six Report to HFS						
<b>Meditech Planning</b>						
Webinar Tutorials	X	X	X	X		
System Access				X		
Workflow Assessment				X		
Best Practice Workflows				X		
Content Review				X		

Project Implementation	Year 1							
	M5	M6	M7	M8	M9	M10	M11	M12
<b>Meditech</b>								
Dictionary Build and Workflow	X	X	X	X				
Review Best Practices	X							
Build Validation	X	X	X	X				
IMO Export File		X						
Interface Set-Up			X					
MPI Conversion testing			X	X				
Interface Testing				X			X	
Integration Testing					X			
Testing/Load Reconcile IMO File					X	X		

Build Finalization					X	X		
SME Training					X			
Build Signoff						X		
End User Training						X	X	
Mock LIVE							X	X
LIVE Creation								X
LIVE Copy								X

<b>Partners</b>								
Develop and Submit Yearly Report to HFS							X	X
Hire AFO BEP								X

<b>Project Implementation</b>	<b>Years 2 and 3</b>			
	Q1	Q2	Q3	Q4
<b>Meditech</b>				
Go LIVE is beginning of Month 10	X			
System Stabilization	X	X		
Optimization Events	X	X		
<b>Partners</b>				
Institute MCO Planning Partnership for Value-Based Payment Strategies	X	X	X	X
Monthly Collection of Baseline Quality Metrics and SDOH Information	X	X	X	X
Ongoing Yearly HFS Reporting				X

[Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)

## 15. Budget

### 1. Annual Budgets across the Proposal

HTC Annual Budgets Template HTC Budget Template.xlsx

When completed, please upload your spreadsheet here. EHR Collaborative HTC Budget Final (5 yrs)

[Budget - Optional] Please upload here any additional documentation or narrative you would like to provide around your budget. Include any documentation regarding budget items in the Construction category (drawings and estimates, formal bids, etc.) (Note: if you wish to include multiple files, you must combine them into a single document.)

#### EHR Collaborative Optional Budget Narrative

Based on the project plan and milestones, Year 1 will be preparation and training for implementation of the new EHR, therefore, there are no individuals served. Once the EHR is launched in Year 2, the Partners number of individuals served can be calculated for Years 2-5, as seen in the chart below. Baseline calculations were utilized from each hospital's inpatient and outpatient census, growing one percent year over year.

	Year 2	Year 3	Year 4	Year 5	Year 6
Loretto	Redacted	Redacted	Redacted	Redacted	Redacted
Roseland	Redacted	Redacted	Redacted	Redacted	Redacted
Saint Anthony	Redacted	Redacted	Redacted	Redacted	Redacted
South Shore	Redacted	Redacted	Redacted	Redacted	Redacted
St. Bernard	Redacted	Redacted	Redacted	Redacted	Redacted
Thorek Memorial	Redacted	Redacted	Redacted	Redacted	Redacted
Thorek Andersonville (Methodist)	Redacted	Redacted	Redacted	Redacted	Redacted
<b>TOTAL</b>	Redacted	Redacted	Redacted	Redacted	Redacted

### 2. Number of Individuals Served

Please project the number of individuals that will be served in each year of funding.

Year 1 Individuals Served **Redacted**

Year 2 Individuals Served **Redacted**

Year 3 Individuals Served **Redacted**

Year 4 Individuals Served **Redacted**

Year 5 Individuals Served **Redacted**

Year 6 Individuals Served **Redacted**

### 3. Alternative Payment Methodologies

Outline any alternative payment methodologies that your proposal might utilize for receiving reimbursement for services from MCOs.

The Partnership will begin using the EHR system by the end of year one of the project. Each hospital will have a standard set of quality metrics configured for standardized calculation, collection, and reporting. The Partnership will conduct an initial data collection period to identify the baseline performance on the standard set of quality measures for the remainder of the project period. It is anticipated this baseline data collection period will occur in year two and reporting will begin ongoing performance on key quality metrics against baselines and targets at regular intervals by the end of the second year of the project period. This data will inform discussions with MCOs regarding alternative payment model participation that includes enhanced payment for performance improvement on quality metrics and total cost of care reduction.

This also allows the Partnership to successfully participate in alternative payment models that require the ability to track and report progress on clinical quality measures, exchange data with MCOs and perform tasks that contribute to controlling the cost of care.

[Alternative Payment Methodologies - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)



## 16. Sustainability

Include a narrative that describes how your budget will decrease reliance on Transformation funding over time and how reimbursements for services and other funding sources will increase and establish sustainability over time. (i.e. how will your project continue to operate without HTC funding?)

In particular, include how services that address social determinants of health will be funded on an ongoing basis (for example, through existing payment models, alternative payment methodologies for Medicaid services, or through other funding sources).

In your narrative, highlight any key assumptions that are critical to making your project sustainable.

Provide your narrative here:

The Partnership's use of discounted group purchasing and transition to a cloud-based, software-as-a-service EHR are key drivers of its sustainability. The Partnership's hospitals will each purchase the new EHR through a contracts for a perpetual license. This means there are no requirements for re-licensing of software after a contract term or mandatory update fees, unlike the current EHR. Because the new EHR has integrated modules and integrates easily with many of the third-party applications used for critical functions such as medication management, it eliminates the cost of developing and maintaining costly data integrations in the future. The functionality that enables patient records and essential documentation to be shared across all areas of the hospital will help eliminate redundancies, cut costs, increase staff productivity, and allow staff to work across multiple departments without additional and costly system training.

The service contract for the new system also features an all-inclusive support fee for each hospital- eliminating unexpected support costs. The discounted group price is significantly lower than what the hospitals could have negotiate individually, which help sustain the long-term cost of the new EHR.

Based on the experiences of other hospitals that have implemented this new system, the Partnership expects to begin realizing financial benefits in the first year following implementation and begin optimizing the system to further enhance cost savings and revenue opportunities that can sustain the system by the end of the transformation project.

Examples include the efficiencies gained and costs avoided through the new ability to:

- manage patient orders from anywhere in the hospital using the computerized physician order entry capabilities
- easily document pre-existing conditions present on admission to ensure CMS reimbursement
- eliminate duplicate testing
- use the discharge tools and patient engagement solutions (including the patient portal, telehealth, call tracking) to prevent readmissions
- populate patient registries and worklists to stratify and contact our most at risk patient populations to ensure their adherence to care protocols and to avoid unnecessary visits to the most costly care settings, such as the emergency department
- ensure patient safety through closed loop medication management and clinical decision support, reducing the risk of legal liability as well as the added costs resulting from extended lengths of stay
- reduce overhead and supply-chain costs by maintaining a perpetual inventory, eliminating paper forms, and using e-commerce to secure the best prices from a global marketplace of suppliers

### **Sources of Sustainability**

**Improved Accounts Receivable and Reduced Claims Denials** – The new EHR system will help the Partnership improve the timeliness and accuracy of billing to MCOs beginning in the first year following implementation. The system includes tools developed to support best practice financial management including automated accounts receivables days calculations, unbilled receivable reports, charge reconciliation and rejection worklists, late charge reports, claims monitoring tools, denial management tools, and automated remittance file import. It is anticipated the Partnership will begin using these advanced revenue management capabilities as soon as the new EHR is implemented and result in incremental year over year improvement in accounts receivable and reduction in denials.

**Increased Outpatient Services** – The new EHR will enable clinical staff to utilize screening and assessment tools, clinical decision support and referral capabilities to direct patients to outpatient services that will help them better manage chronic conditions and reduce inpatient admissions and emergency department visits. This will also result in increased revenue for outpatient services performed at the hospitals in the Partnership.

Increased Revenue from Value-Based Payment Contracts – The new EHR system will allow the hospitals in the Partnership to successfully participate in value-based payment contracts that require the ability to track and report progress on clinical quality measures, exchange data with MCOs and perform tasks that contribute to controlling the cost of care. The goal is to have at least one additional Medicaid managed care organization engaged with a letter of intent to support our project and committed to participating in discussions on value-based payment arrangements.

CMS Payment Penalties Avoided and Other Cost Savings – The new EHR system will enable the Partnership to meet CMS requirements and avoid Medicare payment penalties related to readmissions within 30 days, hospital acquired infections and the promoting interoperability program. The new system will also help hospitals eliminate costs related to technology services that they used to contract for separately, but will now be included in the new system, such as disaster recovery and electronic forms.

Year two of the project will be the first year in which all the hospitals in the Partnership will have the new system fully implemented and will be utilizing the new workflows to improve clinical outcomes and efficiency and collecting and reporting on performance metrics. The performance data collected will help inform the discussions with MCOs regarding opportunities for our hospitals to enter into new value-based contracts. By year three, hospital partners will have enough data to evaluate different value-based payment arrangements with the MCOs and determine the most appropriate approach for each hospital, based on its performance on key metrics and ability to capture performance-based revenue through a value-based payment contract with one or more MCO. It is anticipated that by year four of the project, that all hospitals in the Partnership will be participating successfully in value-based payment contracts that will incrementally enhance revenue to levels that will contribute significantly to the ongoing cost of the EHR.

By the end of Year 5, it is anticipated that the combination of these revenue sources will be sufficient to sustain the cost of the EHR system in future years. The following table models the sustainability of the system after the healthcare transformation collaborative project has concluded. Projections in each category are estimated and will be updated annually to reflect the actual impact of the new EHR system for each hospital in the Partnership.

Post Healthcare Transformation Collaborative Funding Sustainability Model

	Annual Cost to Sustain	Improved AR/ Reduced Denials	Increased Outpatient Revenue	New VBP Contracts	Cost Avoidance/ Savings	Net (0=sustained)
Loretto	Redacted	Redacted	Redacted	Redacted	Redacted	Redacted
Roseland	Redacted	Redacted	Redacted	Redacted	Redacted	Redacted
Saint Anthony	Redacted	Redacted	Redacted	Redacted	Redacted	Redacted
South Shore	Redacted	Redacted	Redacted	Redacted	Redacted	Redacted
St. Bernard	Redacted	Redacted	Redacted	Redacted	Redacted	Redacted
Thorek/Methodist	Redacted	Redacted	Redacted	Redacted	Redacted	Redacted

[Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)